



# Filing an Assurity Worksite Disability Income Claim

## **THE FORMS LISTED BELOW SHOULD ONLY BE USED IF YOU PURCHASED YOUR DISABILITY INCOME POLICY THROUGH AN EMPLOYER**

Disability income insurance provides a benefit when an insured person qualifies for disability as defined in the contract for a covered condition.

This document lists the forms and evidence required for submission of a claim for benefits. Additional information may be necessary to determine benefit eligibility and may require Assurity to order medical records. The required forms listed below can be accessed in the Customer Center on [assurity.com](http://assurity.com), in the policy owner's MyAssurity secure account, or by contacting Assurity's Claims Department at **800-869-0355 Ext. 4484**. **If the claim is for a spouse or a child 18 years of age or older, the claim will require submission by fax, email or mail.**

Proof of Claim may be required within 12 months of the time of loss. Assurity administers many different plans of insurance. Your policy may not include all of the benefits detailed below. Please consult your contract for specific benefits, definitions, provisions, limitations and exclusions.

### **Information Needed/Required Proof for Claim**

- 1) Claimant Statement form #01-070-02255F – to be completed by the claimant. This form can be securely filed electronically in the policy owner's MyAssurity account. If preferred, this form may also be printed and sent to Assurity by fax, email or mail; **and**
- 2) Attending Physician's Statement form #01-014-02255F – You will need to print this form and have the attending physician complete it; the completed form may be sent to Assurity by fax, email or mail; **and**
- 3) Employer Statement form #01-013-02255F – You will need to print this form and have your employer complete it; the completed form may be sent to Assurity by fax, email or mail; **and**
- 4) Confidential Information Authorization form #69-500-05055 – to be completed by claimant. This form can be securely filed electronically in the policy owner's MyAssurity account. If preferred, this form may also be printed and sent to Assurity by fax, email or mail.

### **Additional Rider Benefits**

The rider listed below is available for some Assurity Disability Income products, but is not necessarily a part of your contract. Please review your contract to verify any riders you may have selected.

#### **Potential Benefit**

#### **Information Needed/Required Proof for Claim**

Spouse Accident-only Disability Income Rider

If your spouse wishes to file a claim for Spouse Disability Income Rider benefits, the Disability Income claim forms listed above should be completed by your spouse, your spouse's physician and your spouse's employer. Your spouse must also sign the Authorization form.

*If your contract includes benefits not described in this document or you have questions, please contact Assurity's Claims Department.*

**800-869-0355 Ext. 4484**  
**[claimsinfo@assurity.com](mailto:claimsinfo@assurity.com)**

Assurity is a marketing name for the mutual holding company Assurity Group, Inc. and its subsidiaries. Those subsidiaries include but are not limited to: Assurity Life Insurance Company and Assurity Life Insurance Company of New York. Insurance products and services are offered by Assurity Life Insurance Company in all states except New York. In New York, insurance products and services are offered by Assurity Life Insurance Company of New York, Albany, New York. Product availability, features and rates may vary by state.



Please provide full and complete responses, indicating "none" where applicable. If more space is needed, please attach another sheet. Incomplete information may delay claim. If this claim is on a Spouse Accident Only Disability Rider (W215), check here .

Name	First	Middle	Last	Policy no.
Address	Street address		City	State Zip code +4
Phone no.	( )	Social Security no.	Date of birth	MM/DD/YYYY / / <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>Section I</b>	1. <input type="checkbox"/> Accident <input type="checkbox"/> Illness	2. Date of accident or when illness began	/ /	3. Date last worked	/ /
	4. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, when? _____				
	5. If injured, how and where did accident happen? (If accident occurred at work, please provide details and/or accident report.) _____				
	6. If illness, what is the nature? _____				
	7. Have you filed or will you file a worker's compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	8. Are premiums paid pre-tax? <input type="checkbox"/> Yes <input type="checkbox"/> No				

<b>Section II</b>	1. Please provide the names and addresses of all physicians who have been consulted for any condition during the last five years. Please include dates of consultation. <b>All physicians treating claimant at the time of disability must complete Disability Claim Attending Physician's Statement.</b>				
	Physician's Name	Complete Address	City	State	Zip code +4
	Phone no.	Fax no.	First visit	Last visit	Physician's statement provided?
	( )	( )	/ /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. List the name and complete address of any hospital/clinic where you received medical treatment, consultation, care or services (including diagnostic measures) during the last five years. If additional space is needed, attach a separate sheet of paper.				
Name of hospital/clinic		Complete address (include city, state and zip code)		Date(s) confined	

<b>Section III</b>	Job title _____ Employer _____		
	Please list your normal duties below in order of importance. (Attach second sheet if additional space is necessary.)		
	Duty	Description	Percent of time spent
	1. What percentage of your time is spent on:		
	Heavy labor _____ %	Light labor _____ %	Administration _____ %
Travel _____ %	Supervisory _____ %	Clerical _____ %	
2. Do you have any other occupations? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, describe _____			

**FRAUD NOTICES**

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**VT RESIDENTS:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**I hereby acknowledge that I have read the applicable fraud notice below.**

**I hereby certify the statements contained in this claim form are complete and accurate to the best of my knowledge.**

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Signature of claimant or legal representative

\_\_\_\_\_  
Printed name of person completing this form



This form should be completed by all physicians who were treating the claimant during the time of disability. The patient is responsible for the completion of this form without expense to Assurity Life. Please print or type. If necessary add a separate sheet. Direct any questions to our claims department at the phone numbers shown above.

A. General Information				
Patient's Name (First, Middle, Last)	Policy No.	Date of Birth (MM/DD/YYYY) / /		
Primary Diagnosis including ICD 9 or DSM Code				
B. Complete this section for all conditions				
Symptoms				
Objective Findings				
Are there secondary conditions contributing to the patient's inability to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, what are they?				
When did symptoms first appear?	Date of patient's first visit (MM/DD/YYYY)	Date of the patient's last visit (MM/DD/YYYY)		
How often do you treat/consult the patient?		Date you believe the patient was first unable to work (MM/DD/YYYY)		
Was patient referred to you? Referring physician's name _____ Street address _____ City _____ State _____ Zip+4 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the patient's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain:				
Has the patient undergone surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give date, procedure and result:				
If no, do you expect surgery to be performed in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give date and type of surgery:				
What medications is the patient currently taking? (Please list frequency and dosages.)				
Please indicate other types and frequencies of treatment:				
Has the patient been referred to a medical rehabilitation or therapy program? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give details:				
Have you referred the patient for other types of consultations? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give details:				
Has the patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the following:				
Name of hospital _____ Street address _____ City _____ State _____ Zip+4 _____				
MM/DD/YYYY MM/DD/YYYY				
Confined: ____/____/____ through ____/____/____ Admission time _____ Dismissal time _____				

**Continue to page 2 of this form.**

Indicate class of mental impairment (if applicable):  Class 1—No limitation       Class 2—Slight limitation       Class 3—Moderate limitation  
 Class 4—Marked limitation       Class 5—Severe limitation

What is the patient's current DSM-IV-R diagnosis?  Axis I \_\_\_\_\_  Axis II \_\_\_\_\_  
 Axis III \_\_\_\_\_  Axis IV \_\_\_\_\_  Axis V \_\_\_\_\_

Do you believe this patient is competent to endorse checks/direct the use of proceeds?  Yes  No

**C. Complete this section for pregnancy**

Date of the last menstrual period      /      /      (MM/DD/YYYY)      First date of treatment      /      /      (MM/DD/YYYY)      Expected due date      /      /      (MM/DD/YYYY)

Date of delivery      /      /      (MM/DD/YYYY)      This delivery is expected to be or was:  Vaginal       C-Section

Are there any present complications or anticipated difficulties in connection with:  
a. Pregnancy  Yes  No      b. Delivery  Yes  No      c. Post partum  Yes  No  
If YES, to any of the above, please specify in detail: \_\_\_\_\_  
\_\_\_\_\_

**D. Information about the patient's inability to work. Complete this section for all conditions.**

Briefly describe restrictions (What the patient SHOULD NOT do):  
\_\_\_\_\_

Briefly describe limitations (What the patient CANNOT do):  
\_\_\_\_\_

When was/is the patient able to return to work? Full-time      /      /      (MM/DD/YYYY)      Part-time      /      /      (MM/DD/YYYY)

Does the patient's condition prevent being able to perform self care?  Yes  No      If NO, please complete the following:  
How soon do you expect fundamental changes in the patient's medical condition?  1-2 mos.       3-4 mos.       5-6 mos.       6 + mos.

Give details concerning expected improvement or deterioration:  
\_\_\_\_\_

Additional remarks:  
\_\_\_\_\_

**E. Physician Information**

Attending physician, please print			
Physician's name		Degree	
Phone no. (      )	Fax no. (      )	Specialty	
Street address	City	State	Zip+4
Physician's address			

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**F. Fraud Notices (continued)**

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**I hereby acknowledge that I have read the applicable fraud notice above.**

**I hereby certify the statements above are complete and accurate to the best of my knowledge.**

\_\_\_\_\_  
*Physician's Signature (no stamp)*

\_\_\_\_\_  
*Date (MM/DD/YYYY)*

\_\_\_\_\_  
*TIN or Social Security No.*



9. To the best of your knowledge, is the employee receiving or eligible to receive benefits from any of the following sources?

<input type="checkbox"/> Salary continuance	Amount \$ _____ per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> Short-term Disability (STD)	Amount \$ _____ per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> Long-term Disability (LTD)	Amount \$ _____ per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> Workers' Compensation	Amount \$ _____ per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> Retirement or pension	Amount \$ _____ per _____	From _____ / _____ / _____ to _____ / _____ / _____
<input type="checkbox"/> _____	Lump sum distribution? <input type="checkbox"/> Yes <input type="checkbox"/> No	

10. Remarks

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**FRAUD NOTICES (continued)**

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**I hereby acknowledge that I have read the applicable fraud notice above.**

**I hereby certify the statements contained in this claim form are complete and accurate to the best of my knowledge.**

Signed at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
City State Date (MM/DD/YYYY)

\_\_\_\_\_  
Employer Authorized Representative's Signature

\_\_\_\_\_  
Representative's Printed Name and Title

( ) / ( )  
Office Phone no. and Fax no. (please include area code)

\_\_\_\_\_  
Office E-mail Address



\_\_\_\_\_  
*Legal Name of Applicant/Insured/Claimant (Please print)*

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Date of Birth (MM/DD/YYYY)**

\_\_\_\_\_  
*Legal Name of Additional Applicant/Insured/Claimant (Please print)*

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Date of Birth (MM/DD/YYYY)**

Applicant/Insured/Claimant: List child(ren) and date(s) of birth			
<i>Legal Name</i>	<i>Date of Birth</i>	<i>Legal Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB LLC, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company (*Assurity*), or its reinsurers, any such information. This may include:

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions (*start and stop times*), the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB LLC and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB LLC.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB LLC, consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization shall be valid as long as the insured is continually insured (**authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

\_\_\_\_\_  
*Date (MM/DD/YYYY)*

\_\_\_\_\_  
*Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

\_\_\_\_\_  
*Signature of Additional Applicant/Insured/Claimant or Legal Representative*

\_\_\_\_\_  
*Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

\_\_\_\_\_  
*Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)*

**ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT**